

Mairs Chiropractic
Confidential Patient Health Information

Name _____ Sex M F Date _____ Date of Birth _____ Age _____
Address _____ City _____ Zip _____
H. Phone _____ W. Phone _____ E-mail _____
Referred by _____ Social Security _____
Occupation _____ Employer _____
Have you ever received Chiropractic Care? Yes__ No__ If yes, when? _____

Required Insurance Information

Company Name _____ Phone () _____
Name of Insured _____ Relationship to you _____
Insured ID# (if different than SS#) _____ Insured's Birthday _____
Policy/Group # _____ Plan Name _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____
Secondary reason: _____
Other reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____
What was the initial cause of this complaint? _____
When did this complaint begin? _____
Is the complaint better, worse, or the same since it began? _____
Are you presently under a doctor's care for this complaint? Y/N Doctors name: _____
Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain/complaint imaginable)
How frequent is complaint present. How long does it last? _____
Does anything aggravate the complaint? _____
Does anything make the complaint better? _____
Does this complaint interfere with: work, home life, activities or sleep? Y/N _____
Previous interventions: treatments, medications, surgery, or care you've sought **for your complaint**

4. Past Health History: Please mark any of the following conditions or symptoms that you have now or have experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |

A. Any other symptoms or previous illnesses:

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- B. Previous injury or trauma: _____
Have you ever broken any bones? Which? _____
- C. Allergies _____
- D. Medications: _____
Condition/s you are taking medications for: _____
- F. Surgeries and dates: _____
- G. Pregnancies, Date of Delivery & Outcomes _____

- H. Any menstrual problems? _____

5. Family Health History:

Associated health problems of relatives: _____
Deaths in immediate family: _____

6. Social and Occupational History:

- A. Job description: _____
- B. Recreational activities: _____
- C. Do you take vitamins or supplements? Type and how often. _____
- D. Smoking and alcohol use. How often. _____

On a scale of 1 – 10. How committed are you to resolving this complaint? _____

Are there any other health concerns you would like to address? _____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Signature _____ Date _____

Doctors Signature _____ Date _____